



Facility Name & ID Number Friendship Vill. Schaumburg# 0023218 Report Period Beginning: 04/01/04 Ending: 03/31/05

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>250</u>	Skilled (SNF)	<u>250</u>	<u>91,250</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>250</u>	TOTALS	<u>250</u>	<u>91,250</u>	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>12,817</u>	<u>29,518</u>	<u>8,227</u>	<u>50,562</u>	8
9	SNF/PED					9
10	ICF	<u>7,081</u>	<u>26,376</u>		<u>33,457</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>19,898</u>	<u>55,894</u>	<u>8,227</u>	<u>84,019</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 92.08%

D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)Home Health, Clinic, Adult Day Care

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☒ NO ☐

I. On what date did you start providing long term care at this location?

Date started 1/1/77

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date \_\_\_\_\_ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter numberof beds certified 250 and days of care provided 8,227Medicare Intermediary Mutual of Omaha

## IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED  
CASH\* ☐ CASH\* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 3/31/05 Fiscal Year: 3/31/05

\* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

Page 3

Facility Name &amp; ID Number Friendship Vill. Schaumburg # 0023218 Report Period Beginning: 04/01/04 Ending: 03/31/05

## V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	1,412,905	226,406	200,057	1,839,368		1,839,368	(870,949)	968,419		1
2	Food Purchase		1,077,667		1,077,667		1,077,667	(512,048)	565,619		2
3	Housekeeping	325,628	79,538	3,167	408,333		408,333	(353,265)	55,068		3
4	Laundry	185,276	42,861		228,137		228,137	(18,459)	209,678		4
5	Heat and Other Utilities			812,350	812,350		812,350	(699,947)	112,403		5
6	Maintenance	726,607	100,546	602,627	1,429,780		1,429,780	(1,238,073)	191,707		6
7	Other (specify):*			389,267	389,267		389,267	(335,405)	53,862		7
8	<b>TOTAL General Services</b>	2,650,416	1,527,018	2,007,468	6,184,902		6,184,902	(4,028,146)	2,156,756		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			4,800	4,800		4,800		4,800		9
10	Nursing and Medical Records	5,761,496	328,736	165,833	6,256,065		6,256,065	(3,136)	6,252,929		10
10a	Therapy	75,799			75,799		75,799		75,799		10a
11	Activities	383,176	2,233		385,409		385,409		385,409		11
12	Social Services	98,003	2,723	18	100,744		100,744		100,744		12
13	CNA Training										13
14	Program Transportation			117,452	117,452		117,452		117,452		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	6,318,474	333,692	288,103	6,940,269		6,940,269	(3,136)	6,937,133		16
	<b>C. General Administration</b>										
17	Administrative	901,879			901,879		901,879	(262,146)	639,733		17
18	Directors Fees			117,587	117,587		117,587	(102,221)	15,366		18
19	Professional Services			361,233	361,233		361,233	(321,969)	39,264		19
20	Dues, Fees, Subscriptions & Promotions			118,310	118,310		118,310	(2,000)	116,310		20
21	Clerical & General Office Expenses	955,806	270,312	468,892	1,695,010		1,695,010	(682,186)	1,012,824		21
22	Employee Benefits & Payroll Taxes			3,086,540	3,086,540		3,086,540	(925,528)	2,161,012		22
23	Inservice Training & Education										23
24	Travel and Seminar			40,425	40,425		40,425	(5,935)	34,490		24
25	Other Admin. Staff Transportation			17,301	17,301		17,301	(13,458)	3,843		25
26	Insurance-Prop.Liab.Malpractice			529,235	529,235		529,235	(457,534)	71,701		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	1,857,685	270,312	4,739,523	6,867,520		6,867,520	(2,772,977)	4,094,543		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	10,826,575	2,131,022	7,035,094	19,992,691		19,992,691	(6,804,259)	13,188,432		29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

## STATE OF ILLINOIS

Page 4

Facility Name & ID Number Friendship Vill. Schaumburg

#0023218

Report Period Beginning:

04/01/04

Ending:

03/31/05

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			3,889,716	3,889,716		3,889,716	(3,044,758)	844,958			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,021,312	2,021,312		2,021,312	(1,796,236)	225,076			32
33	Real Estate Taxes			580,200	580,200		580,200	(499,919)	80,281			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			6,491,228	6,491,228		6,491,228	(5,340,913)	1,150,315			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	509,435	802,563	561,752	1,873,750		1,873,750	(428,089)	1,445,661			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops	39,172		52,816	91,988		91,988	(91,988)				41
42	Provider Participation Fee			136,875	136,875		136,875		136,875			42
43	Other (specify):*			3,209,213	3,209,213		3,209,213	(3,209,213)				43
44	<b>TOTAL Special Cost Centers</b>	548,607	802,563	3,960,656	5,311,826		5,311,826	(3,729,290)	1,582,536			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	11,375,182	2,933,585	17,486,978	31,795,745		31,795,745	(15,874,462)	15,921,283			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Friendship Vill. Schaumburg# 0023218Report Period Beginning: 04/01/04Ending: 03/31/05**VI. ADJUSTMENT DETAIL****A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.****In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

		1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(973)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(69,900)	43		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(15,803,589)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (15,874,462)		\$	30

OHF USE ONLY						
48		49	50	51	52	

**B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)**

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ #####		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

**C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)**

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

NON-ALLOWABLE EXPENSES			Amount	Reference
1		\$		1
2				2
3	Misc. Health Care Revenue	(228)	10	3
4	Wheelchair Rental	(2,526)	10	4
5	Laundry Room Income	(1,131)	22	5
6	Village Store Income	(91,988)	43	6
7	Space / Clinic Rental	(20,200)	6	7
8	Vending Machines	(2,384)	2	8
9	Gain/Loss Fixed Assets	(58)	6	9
10	Miscellaneous Income	(156,432)	31	10
11	Investment Income	(389,534)	35	11
12	Damage Claims Paid	(11,042)	26	12
13	Special Events Corporate	(8,218)	43	13
14	Community Based Programming	(984)	43	14
15	Partnership Initiatives	(2,252)	43	15
16	Corporate Philanthropy	(2,800)	26	16
17	Sales / Marketing	(1,438,650)	43	17
18	Wages - Pavilion Associates	(62,544)	43	18
19	Wages - Al. Waterfall	(105,521)	43	19
20	Village Events	(19)	43	20
21	Senior Fitness	(79,812)	43	21
22	Chapel Expense - IL / AL	(379)	43	22
23	Adult Day Service	(271,476)	43	23
24	Assisted Living	(440,491)	43	24
25	Wages - Home Health	(324,474)	39	25
26	Wages - Clinic	(103,129)	39	26
27	Clinic Supplies	(486)	39	27
28	IL / AL Programs	(151,643)	43	28
29	Bank Raising	(249,608)	43	29
30	Bank & Investment Fees	(110,544)	21	30
31	Non-allowable Legal Fees	(77,468)	19	31
32	Refinancing	(22,068)	32	32
33	Remodeling Fee	(13,856)	32	33
34	Capitalized R&M	(24,038)	6	34
35				35
36	Director's Expense	(6,538)	18	36
37	Out-of-State Seminar Expense	(5,935)	24	37
38	Out-of-State Travel Expense	(13,458)	23	38
39	Wages - Housekeeping - Apartments	(321,460)	43	39
40	Non-HCC - Dietary	(979,949)	1	40
41	Non-HCC - Food	(508,691)	2	41
42	Non-HCC - Housekeeping	(383,265)	3	42
43	Non-HCC - Laundry	(14,459)	4	43
44	Non-HCC - Heat & Utilities	(699,947)	5	44
45	Non-HCC - Maintenance	(1,193,785)	6	45
46	Non-HCC - Disposal/ Waste	(385,465)	7	46
47	Non-HCC - Administrative	(262,146)	17	47
48	Non-HCC - Director's Fees	(95,683)	18	48
49	Non-HCC - Professional Fees	(244,591)	19	49
50	Non-HCC - Chemical & General	(415,629)	21	50
51	Non-HCC - Employee Benefits	(885,520)	22	51
52	Non-HCC - Insurance	(446,492)	26	52
53	Non-HCC - Depreciation	(3,344,750)	30	53
54	Non-HCC - Interest	(1,481,570)	32	54
55	Non-HCC - Real Estate Tax	(499,919)	33	55
56	Misc Income - Jury Duty	(82)	10	56
57	Misc Income - Processing Fee	(84)	21	57
58	Misc Income - Medical Plan Expense Reimb	(40,000)	22	58
59				59
60				60
61				61
62				62
63				63
64				64
65				65
66				66
67				67
68				68
69				69
70				70
71				71
72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90				90
91				91
92				92
93				93
94				94
95				95
96				96
97				97
98				98
99				99
100				100
101	Total		(15,803,589)	101

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Friendship Vill. Schaumburg

# 0023218

Report Period Beginning:

04/01/04

Ending:

03/31/05

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	(870,949)											(870,949)	1
2	Food Purchase	(512,048)											(512,048)	2
3	Housekeeping	(353,265)											(353,265)	3
4	Laundry	(18,459)											(18,459)	4
5	Heat and Other Utilities	(699,947)											(699,947)	5
6	Maintenance	(1,238,073)											(1,238,073)	6
7	Other (specify):*	(335,405)											(335,405)	7
8	<b>TOTAL General Services</b>	<b>(4,028,146)</b>											<b>(4,028,146)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records	(3,136)											(3,136)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	<b>TOTAL Health Care and Programs</b>	<b>(3,136)</b>											<b>(3,136)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	(262,146)											(262,146)	17
18	Directors Fees	(102,221)											(102,221)	18
19	Professional Services	(321,969)											(321,969)	19
20	Fees, Subscriptions & Promotions	(2,000)											(2,000)	20
21	Clerical & General Office Expenses	(682,186)											(682,186)	21
22	Employee Benefits & Payroll Taxes	(925,528)											(925,528)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(5,935)											(5,935)	24
25	Other Admin. Staff Transportation	(13,458)											(13,458)	25
26	Insurance-Prop.Liab.Malpractice	(457,534)											(457,534)	26
27	Other (specify):*													27
28	<b>TOTAL General Administration</b>	<b>(2,772,977)</b>											<b>(2,772,977)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(6,804,259)</b>											<b>(6,804,259)</b>	<b>29</b>

### Summary B

**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

[illegible]



**VII. RELATED PARTIES**

**A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				See Attached		

**B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.** ☐ YES ☒ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Friendship Vill. Schaumburg# 0023218Report Period Beginning: 04/01/04Ending: 03/31/05

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 0	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Friendship Vill. Schaumburg# 0023218Report Period Beginning: 04/01/04Ending: 03/31/05

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 0	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Friendship Vill. Schaumburg

# 0023218

Report Period Beginning: 04/01/04

Ending: 03/31/05

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V		\$			\$	\$
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 0	\$ *

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Friendship Vill. Schaumburg

# 0023218

Report Period Beginning: 04/01/04

Ending: 03/31/05

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V		\$			\$	\$
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 0	\$ *

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Friendship Vill. Schaumburg

# 0023218

Report Period Beginning: 04/01/04

Ending: 03/31/05

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 0	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Friendship Vill. Schaumburg# 0023218Report Period Beginning: 04/01/04Ending: 03/31/05

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V		\$			\$	\$
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 0	\$ *

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Friendship Vill. Schaumburg# 0023218Report Period Beginning: 04/01/04Ending: 03/31/05

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 0	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT



Facility Name & ID Number Friendship Vill. Schaumburg# 0023218Report Period Beginning: 04/01/04Ending: 03/31/05

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 0	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Friendship Vill. Schaumburg

# 0023218

Report Period Beginning: 04/01/04

Ending: 03/31/05

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V		\$			\$	\$
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 0	\$ *

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Friendship Vill. Schaumburg # 0023218 Report Period Beginning: 04/01/04 Ending: 03/31/05

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).  
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.  
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Friendship Vill. Schaumburg# 0023218

Report Period Beginning:

04/01/04Ending: 03/31/05

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Apartment CommunityStreet Address 350 W. Schaumburg RoadCity / State / Zip Code Schaumburg, IL 60194Phone Number ( 847) 884-5000Fax Number ( 847) 884-5718

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	<u>Dietary</u>	<u>Meals Ratio</u>	<u>463,383</u>	<u>2</u>	<u>\$ 1,839,368</u>	<u>\$ 1,412,905</u>	<u>243,969</u>	<u>\$ 968,419</u>	1
2	<u>Food Purchase</u>	<u>Meals Ratio</u>	<u>463,383</u>	<u>2</u>	<u>1,074,310</u>		<u>243,969</u>	<u>565,619</u>	2
3	<u>Housekeeping</u>	<u>Square Feet</u>	<u>433,975</u>	<u>2</u>	<u>408,333</u>	<u>325,628</u>	<u>58,526</u>	<u>55,068</u>	3
4	<u>Laundry</u>	<u>Pounds</u>	<u>865,139</u>	<u>2</u>	<u>228,137</u>	<u>185,276</u>	<u>795,139</u>	<u>209,678</u>	4
5	<u>Heat &amp; Utilities</u>	<u>Square Feet</u>	<u>422,975</u>	<u>2</u>	<u>812,350</u>		<u>58,526</u>	<u>112,403</u>	5
6	<u>Maintenance</u>	<u>Square Feet</u>	<u>422,975</u>	<u>2</u>	<u>1,385,492</u>	<u>726,607</u>	<u>58,526</u>	<u>191,707</u>	6
7	<u>Other (Disposal, Waste)</u>	<u>Square Feet</u>	<u>422,975</u>	<u>2</u>	<u>389,267</u>		<u>58,526</u>	<u>53,862</u>	7
8	<u>Administrative</u>	<u>Employee Ratio</u>	<u>375</u>	<u>2</u>	<u>901,879</u>	<u>901,879</u>	<u>266</u>	<u>639,733</u>	8
9	<u>Director's Fees</u>	<u>Square Feet</u>	<u>422,975</u>	<u>2</u>	<u>111,049</u>		<u>58,526</u>	<u>15,366</u>	9
10	<u>Professional Services</u>	<u>Square Feet</u>	<u>422,975</u>	<u>2</u>	<u>283,765</u>		<u>58,526</u>	<u>39,264</u>	10
11	<u>Clerical &amp; General</u>	<u>Employee Ratio</u>	<u>375</u>	<u>2</u>	<u>1,427,853</u>	<u>955,806</u>	<u>266</u>	<u>1,012,824</u>	11
12	<u>Employee Benefits</u>	<u>Employee Ratio</u>	<u>375</u>	<u>2</u>	<u>3,046,540</u>		<u>266</u>	<u>2,161,012</u>	12
13	<u>Insurance</u>	<u>Square Feet</u>	<u>422,975</u>	<u>2</u>	<u>518,193</u>		<u>58,526</u>	<u>71,701</u>	13
14	<u>Depreciation</u>	<u>Actual</u>		<u>1</u>	<u>3,889,716</u>			<u>844,958</u>	14
15	<u>Interest</u>	<u>Square Feet</u>	<u>422,975</u>	<u>2</u>	<u>1,626,654</u>		<u>58,526</u>	<u>225,076</u>	15
16	<u>Real Estate Tax</u>	<u>Square Feet</u>	<u>422,975</u>	<u>2</u>	<u>580,200</u>		<u>58,526</u>	<u>80,281</u>	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				<u>\$ 18,523,106</u>	<u>\$ 4,508,101</u>		<u>\$ 7,246,971</u>	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Friendship Vill. Schaumburg# 0023218

Report Period Beginning:

04/01/04Ending: 03/31/05

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$			1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Friendship Vill. Schaumburg# 0023218

Report Period Beginning:

04/01/04Ending: 03/31/05

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2  Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4  Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$			1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Friendship Vill. Schaumburg# 0023218

Report Period Beginning:

04/01/04Ending: 03/31/05

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2  Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4  Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$			1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Friendship Vill. Schaumburg# 0023218

Report Period Beginning:

04/01/04Ending: 03/31/05

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2  Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4  Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT



Facility Name & ID Number Friendship Vill. Schaumburg# 0023218

Report Period Beginning:

04/01/04Ending: 03/31/05

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$			1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Friendship Vill. Schaumburg# 0023218

Report Period Beginning:

04/01/04Ending: 03/31/05

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$			1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Friendship Vill. Schaumburg# 0023218

Report Period Beginning:

04/01/04Ending: 03/31/05

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2  Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4  Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8  Facility Units	9  Allocation (col.8/col.4)x col.6	
1					\$	\$			1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Friendship Vill. Schaumburg# 0023218

Report Period Beginning:

04/01/04Ending: 03/31/05

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$			1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Friendship Vill. Schaumburg# 0023218

Report Period Beginning:

04/01/04Ending: 03/31/05

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2  Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4  Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$			1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

**A. Interest:** (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	IL Health Facility		X				\$ 16,695,000	\$ 6,170,000			\$ 468,384	1	
2	Refinancing Fees		X								194,025	2	
3	New Issue		X				30,770,000	30,133,869			1,323,779	3	
4												4	
5	See Supplemental Schedule											5	
	Working Capital												
6												6	
7												7	
8	See Supplemental Schedule											8	
9	TOTAL Facility Related						\$ 47,465,000	\$ 36,303,869			\$ 1,986,188	9	
	B. Non-Facility Related*												
10	Investment Income		X								(359,534)	10	
11	Non-HCC Adjustment										(1,401,578)	11	
12												12	
13	See Supplemental Schedule											13	
14	TOTAL Non-Facility Related						\$				\$ (1,761,112)	14	
15	TOTALS (line 9+line14)						\$ 47,465,000	\$ 36,303,869			\$ 225,076	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line #

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3		4		5		6		7		8		9		10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
	A. Directly Facility Related																		
	Long-Term																		
1							\$	\$			\$	1							
2												2							
3												3							
4												4							
5												5							
6												6							
7	TOTAL Long-Term											7							
	Working Capital																		
8							\$	\$			\$	8							
9												9							
10												10							
11												11							
12												12							
13												13							
14	TOTAL Working Capital											14							
	B. Non-Facility Related*																		
15							\$	\$			\$	15							
16												16							
17												17							
18												18							
19												19							
20	TOTAL Non-Facility Related											20							

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

## B. Real Estate Taxes

**NOTES:**

1. Please indicate a negative number by use of brackets ( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

**SEE ACCOUNTANTS' COMPILATION REPORT**



**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates    **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2004 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Friendship Vill. Schaumburg COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0023218

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1.	<u>See attached</u>	<u>Long-Term Care Property</u>	\$ <u>251,391.47</u>	\$ <u>34,784.41</u>
2.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
3.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
4.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
5.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
6.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
7.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
8.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
9.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
10.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
		<b>TOTALS</b>	\$ <u><u>251,391.47</u></u>	\$ <u><u>34,784.41</u></u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES            NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates    **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

**2004 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Friendship Vill. Schaumburg COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0023218

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
2. <u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
3. <u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
4. <u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
5. <u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
6. <u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
7. <u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
8. <u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
9. <u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
10. <u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
<b>TOTALS</b>		\$ <u>                    </u>	\$ <u>                    </u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?            YES            NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2005.

X. BUILDING AND GENERAL INFORMATION:

A.
Square Feet:
422,975

B. General Construction Type:

Exterior
Brick

Frame
Steel

Number of Stories
3

C.
Does the Operating Entity?

☒ (a) Own the Facility
☐ (b) Rent from a Related Organization.
☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D.
Does the Operating Entity?

☒ (a) Own the Equipment
☐ (b) Rent equipment from a Related Organization.
☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E.
List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

590 Independent Living Apartments - approximate square feet 364,449

F.
Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES
☒ NO

If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1		approx. 50 acres	1977	\$ 132,065	1
2					2
3	TOTALS			\$ 132,065	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Friendship Vill. Schaumburg

# 0023218

Report Period Beginning:

04/01/04

Ending:

03/31/05

**XL OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9
Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Accumulated Depreciation
4	180	1997	1997	\$ 1,760,825	\$ 44,021	40	\$ 44,021	\$
5	10	1993	1993	1,102,771	27,569	40	27,569	
6	60	1998	1998	2,934,069	73,352	40	73,352	
7								
8								
<b>Improvement Type**</b>								
9	Various	1977		106,955		20		
10	Various	1986		60,910		20		
11	Various	1988		43,130		20		
12	Various	1989		64,518		20		
13	Various	1990		47,446		20		
14	Various	1991		45,448		20		
15	Various	1992		13,719		20		
16	Various	1993		16,879		20		
17	Various	1994		36,357		20		
18	Various	1995		272,667		20		
19	Various	1996		204,229		20		
20	Various	1997		636,288		20		
21	Various	1998		1,055,440		20		
22	Various	1999		274,179		20		
23	Various	2000		266,127		20		
24	Various	2001		1,307,803		20		
25								
26								
27								
28								
29								
30								
31								
32								
33								
34								
35								
36								

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	<a href="#">Related Building Company (Pages 12-BLDG &amp; 12A-BLDG)</a>								67
68	<a href="#">Related Party Allocations (Pages 12-REP &amp; 12A-REP)</a>								68
69	<a href="#">Financial Statement Depreciation</a>			<b>700,016</b>		<b>700,016</b>			69
70	TOTAL (lines 4 thru 69)		\$    10,249,760	\$    844,958		\$    844,958	\$	\$	70

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**XI. OWNERSHIP COSTS (continued)**

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 10,249,760	\$ 844,958		\$ 844,958	\$	\$	1
2	Mailbox Cylinders (631)	2002	87		20				2
3	Bathroom Fixtures (3359)	2002	465		20				3
4	Med Lamps (668)	2002	92		20				4
5	Shower Unit (1757)	2002	243		20				5
6	Drywall (727)	2002	101		20				6
7	Bracket Fixtures (907)	2002	126		20				7
8	Bracket Fixtures (602)	2002	83		20				8
9	Exit Bar (975)	2002	135		20				9
10	Swing Door Control (758)	2002	105		20				10
11	Door Stop/Threshold (550)	2002	76		20				11
12	Sliding Door Repairs (1100)	2002	152		20				12
13	Duct Heater (1963)	2002	272		20				13
14	Ic Console Relay (685)	2002	95		20				14
15	Air Conditioners (99018)	2002	13,704		20				15
16	Tuckpointing & Window Replacement (116368)	2002	16,105		20				16
17	Landscaping (35825)	2002	4,958		20				17
18	Exterior Signage (40839)	2002	5,652		20				18
19	E&F Phase II (218307)	2002	218,307		20				19
20	Special Care Renovation (25191)	2002	25,191		20				20
21	Interior Signage (35825)	2002	4,884		20				21
22	Dock Rebuild (10814)	2002	1,497		20				22
23	Replace Doors (4690)	2002	649		20				23
24	Replace Hot Water Heater (137135)	2002	18,979		20				24
25	Faucet Repairs (2311)	2002	320		20				25
26	Shower Unit (3515)	2002	486		20				26
27	Cooler Repairs (701)	2002	97		20				27
28	Sensor Repairs (673)	2002	93		20				28
29	Thermostat (793)	2002	110		20				29
30	Thermostat (823)	2002	114		20				30
31	Staining Of Beams (2645)	2002	366		20				31
32	Speaker Repairs (656)	2002	91		20				32
33	Light Fixtures (975)	2002	135		20				33
34	TOTAL (lines 1 thru 33)		\$ 10,563,530	\$ 844,958		\$ 844,958	\$	\$	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 10,563,530	\$ 844,958		\$ 844,958	\$	\$	1
2	Light Fixtures (516)	2002	71		20				2
3	Toilets (542)	2002	75		20				3
4	Thermostat (501)	2002	69		20				4
5	Roof Scudder (707)	2002	98		20				5
6	Exit Bar Repairs (641)	2002	89		20				6
7	Traffic Signs (1081)	2002	150		20				7
8	Leak Repairs (673)	2002	93		20				8
9	Outdoor Pole Lighting (3502)	2002	485		20				9
10	Ac Repairs (4100)	2002	567		20				10
11	Ac Repairs (510)	2002	71		20				11
12	Air Compressor Repairs (1007)	2002	139		20				12
13	Compressor (827)	2002	114		20				13
14	Heat Exchanger Repairs (523)	2002	72		20				14
15	Ac Repairs (1294)	2002	1,294		20				15
16	Tile Repairs (2400)	2002	2,400		20				16
17	Whirlpool Bath (2077)	2002	2,077		20				17
18	E&F Section Repairs (13460)	2002	13,460		20				18
19	Shower/Tile Repairs (3100)	2002	3,100		20				19
20	Counter Tops (959)	2002	959		20				20
21	Valve Repairs (1536)	2002	1,536		20				21
22	Chiller Repairs (1475)	2002	204		20				22
23	Fan/Belt Repairs (510)	2002	71		20				23
24	Lumber (866)	2002	120		20				24
25	Door Switches (673)	2002	93		20				25
26	Paint (591)	2002	82		20				26
27	Door Repair (2109)	2002	292		20				27
28	Door Repair (1573)	2002	218		20				28
29	Paint (3106)	2002	430		20				29
30	Paint (632)	2002	87		20				30
31	Lumber (1038)	2002	144		20				31
32	Rooftop Hatch Repair (1767)	2002	245		20				32
33	Blower Bearing - Hvac (544)	2002	75		20				33
34	TOTAL (lines 1 thru 33)		\$ 10,592,509	\$ 844,958		\$ 844,958	\$	\$	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 10,592,509	\$ 844,958		\$ 844,958	\$	\$	1
2	Osha - Repair (850)	2002	850		20				2
3	Osha - Repair (16392)	2002	16,392		20				3
4	Osha - Repair (20781)	2002	20,781		20				4
5	Painting (3277)	2002	3,277		20				5
6	Laundry Shute (1040)	2002	144		20				6
7	Security System (619)	2002	86		20				7
8	Code Alert Repair (997)	2002	138		20				8
9	Security System (765)	2002	106		20				9
10	Plumbing/Electrical (601)	2003	83		20				10
11	Plumbing/Electrical (954)	2003	132		20				11
12	Wall Fixtures (576)	2003	80		20				12
13	Emergency Management Systems (735)	2003	102		20				13
14	Cabinets (1704)	2003	1,704		20				14
15	Countertop (950)	2003	131		20				15
16	Security System (696)	2003	96		20				16
17	Security System (1273)	2003	176		20				17
18	Healthcare E Pavilion	2003	405,872		20				18
19	Friendship Hall Remodel (7705)	2003	1,066		20				19
20	Healthcare F Pavilion	2003	434,026		20				20
21	Air Conditioning (47,961)	2003	6,638		20				21
22	Tuckpointing & Window Replacement (132,595)	2003	18,351		20				22
23	Skylight Shades (1080)	2003	150		20				23
24	Ship/Receive Dock Electrical (3339)	2003	462		20				24
25	Emergency Generator (5907)	2003	818		20				25
26	A&D Pavilion Fascia (149,624)	2003	20,708		20				26
27	Garage Masonry Work (7395)	2003	1,024		20				27
28	Computer Room Upgrade (11,265)	2003	1,559		20				28
29	Hvac (3758)	2003	520		20				29
30	Lounge Renovation	2003	30,223		20				30
31	Pavement Improvement (13,652)	2003	1,889		20				31
32	Memory Garden (342,283)	2003	47,372		20				32
33	Fire Protection Valve Work (8690)	2003	1,203		20				33
34	TOTAL (lines 1 thru 33)		\$ 11,608,669	\$ 844,958		\$ 844,958	\$	\$	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.



**XI. OWNERSHIP COSTS (continued)**

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 11,608,669	\$ 844,958		\$ 844,958	\$	\$	1
2	Exit Signs (1325)	2003	183		20				2
3	Dry System Repair (1412)	2003	195		20				3
4	Air Compressor (509)	2003	71		20				4
5	Door Sensor System (1828)	2003	253		20				5
6	Electrical Ballasts (742)	2003	103		20				6
7	Roof Repair (588)	2003	81		20				7
8	Door & Automatic Opener (1798)	2003	249		20				8
9	Roof Repair (575)	2003	80		20				9
10	A/C Repair (535)	2003	74		20				10
11	Walk-In Freezer Repair (705)	2003	98		20				11
12	Door Repairs	2003	771		20				12
13	Door Repairs	2003	2,133		20				13
14	Decorating / Wallcovering	2003	557		20				14
15	Wandering Alarm System Antenna (1022)	2003	141		20				15
16	Security System Repair (1555)	2003	215		20				16
17	Wander Alarm Repair (528)	2003	73		20				17
18	Wiring (716)	2003	99		20				18
19	Lock / Panic Bar (525)	2004	73		20				19
20	Roof Repair (1707)	2004	236		20				20
21	Auto Door Lock	2004	929		20				21
22	Fire System (1203)	2004	167		20				22
23	Main Entrance Repairs (276,799)	2004	38,309		20				23
24	Electrical Auto Transfer Switch - Hcc	2004	5,249		20				24
25	Door Repair (830)	2004	115		20				25
26	Ceiling Fans (783)	2004	108		20				26
27	Fire Pump Repair (830)	2004	115		20				27
28	Faucet, Lighting, Electrical (929)	2004	129		20				28
29	Ceiling Fans (762)	2004	105		20				29
30	Faucets (1115)	2004	154		20				30
31	Door Repair (1360)	2004	188		20				31
32	Roof Repairs (1037)	2004	143		20				32
33	Entry Canopy (1400)	2004	194		20				33
34	TOTAL (lines 1 thru 33)		\$ 11,660,259	\$ 844,958		\$ 844,958	\$	\$	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**XI. OWNERSHIP COSTS (continued)**

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 11,660,259	\$ 844,958		\$ 844,958	\$	\$	1
2	Condensing Unit Repair (572)	2004	79		20				2
3	Hvac - Blower (627)	2004	87		20				3
4	Condensor Fan Motor (964)	2004	133		20				4
5	Hvac - Heating Elements (2068)	2004	286		20				5
6	Control Thermostat - Boiler Rm (525)	2004	73		20				6
7	Control Box (749)	2004	749		20				7
8	Wiring Ansul System (1090)	2004	151		20				8
9	Reroute Cables, Repair Pull Cord (503)	2004	70		20				9
10	Reinforcement Of A/C Platforms (5074)	2005	702		20				10
11	Natural Gas Generator (3251)	2005	450		20				11
12	Main Dining Room Renovation (112,878)	2005	15,622		20				12
13	Air Conditioners (94,218)	2005	13,040		20				13
14	Tuck Pointing / Window Replacement (135,740)	2005	18,786		20				14
15	Exterior Wood Trim Repairs (174,138)	2005	24,101		20				15
16	Pine Tree / Roger Smith Memorial Garden (1090)	2005	151		20				16
17	Water Heater Replacement - B&D Pav. (20,770)	2005	2,875		20				17
18	Sound System - Hcc	2005	14,183		20				18
19	Wanderguard Transmitters	2005	864		20				19
20	Donor Recognition Wall (11,464)	2005	1,587		20				20
21	Gas Valve (641)	2005	89		20				21
22	Gas Valve And Inducer Motor (679)	2005	94		20				22
23	Wiring For Static Pressure Control (950)	2005	131		20				23
24	Laundry Chute Door Air Seal (860)	2005	119		20				24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,754,680	\$ 844,958		\$ 844,958	\$	\$	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 11,754,680	\$ 844,958		\$ 844,958	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,754,680	\$ 844,958		\$ 844,958	\$	\$	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 11,754,680	\$ 844,958		\$ 844,958	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,754,680	\$ 844,958		\$ 844,958	\$	\$	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 11,754,680	\$ 844,958		\$ 844,958	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,754,680	\$ 844,958		\$ 844,958	\$	\$	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$ 11,754,680	\$ 844,958		\$ 844,958	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,754,680	\$ 844,958		\$ 844,958	\$	\$	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		\$ 11,754,680	\$ 844,958		\$ 844,958	\$	\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,754,680	\$ 844,958		\$ 844,958	\$	\$	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$		4
5											5
6											6
7											7
8											8
9	Improvement Type**										9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
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26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.



XI. OWNERSHIP COSTS (continued)								
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.								
1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70	TOTAL (lines 4 thru 69)		\$	\$	\$	\$	\$	70

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation		
4					\$	\$		\$	\$		4	
5											5	
6											6	
7											7	
8											8	
	Improvement Type**											
9											9	
10											10	
11											11	
12											12	
13											13	
14											14	
15											15	
16											16	
17											17	
18											18	
19											19	
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28											28	
29											29	
30											30	
31											31	
32											32	
33											33	
34											34	
35											35	
36											36	

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
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60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$	\$		\$	\$	\$	70

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,767,575	\$	\$	\$	10	\$	71
72	Current Year Purchases	417,991				10		72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 2,185,566	\$	\$	\$		\$	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		96 Chevy Pick-Up	1996	\$ 8,996	\$	\$	\$	5	\$	76
77										77
78										78
79										79
80	TOTALS			\$ 8,996	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 14,081,307	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 844,958	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 844,958	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Marketing Office (251,389) - 2002	\$ 34,792	\$ 3,479	\$ 13,916	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 34,792	\$ 3,479	\$ 13,916	91

G. Construction-in-Progress

	Description	Cost	
92	Garden home construction	\$	92
93	and renovation of common		93
94	areas within the Village.	7,929,409	94
95		\$ 7,929,409	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

**1. Name of Party Holding Lease:** N/A

**If NO, see instructions.**

14. \_\_\_\_\_ /2008 \$ \_\_\_\_\_

	1	2	3	4	
	Use	Model Year and Make	Monthly Lease Payment	Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

**\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.**

**SEE ACCOUNTANTS' COMPILATION REPORT**

**A. TYPE OF TRAINING PROGRAM** (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p><b>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?</b></p> <p> <input type="checkbox"/> YES      <input checked="" type="checkbox"/> NO                 </p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p><b>2. CLASSROOM PORTION:</b></p> <p>                     IN-HOUSE PROGRAM <input type="checkbox"/>                      IN OTHER FACILITY <input type="checkbox"/>                      COMMUNITY COLLEGE <input type="checkbox"/>                      HOURS PER CNA _____                 </p>	<p><b>3. CLINICAL PORTION:</b></p> <p>                     IN-HOUSE PROGRAM <input type="checkbox"/>                      IN OTHER FACILITY <input type="checkbox"/>                      HOURS PER CNA _____                 </p>
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**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		1		2		3	4
		Facility					
		Drop-outs	Completed	Contract	Total		
1	Community College Tuition	\$	\$	\$	\$		
2	Books and Supplies						
3	Classroom Wages (a)						
4	Clinical Wages (b)						
5	In-House Trainer Wages (c)						
6	Transportation						
7	Contractual Payments						
8	CNA Competency Tests						
9	TOTALS	\$	\$	\$	\$		
10	SUM OF line 9, col. 1 and 2 (e)	\$					

**C. CONTRACTUAL INCOME**

In the box below record the amount of income your facility received training CNAs from other facilities.

\$ \_\_\_\_\_

**D. NUMBER OF CNAs TRAINED**

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
 (c) For in-house training programs only. Do not include fringe benefits.  
 (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.  
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.  
**SEE ACCOUNTANTS' COMPILATION REPORT**

**XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)**

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 184,072	\$		\$ 184,072	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			103,942			103,942	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 01	hrs	36,774		220,023			256,797	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				745,670		745,670	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental			472,661		53,715	56,893		583,269	13
14	TOTAL			\$ 509,435		\$ 561,752	\$ 802,563		\$ 1,873,750	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 5,768,370	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	2,068,646		3
4	Supply Inventory (priced at )	96,845		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	546,743		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <a href="#">See Attached Schedule</a>	3,178,929		9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 11,659,533	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	10,744,414		12
13	Land	12,468,204		13
14	Buildings, at Historical Cost	58,211,441		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	6,003,114		16
17	Accumulated Depreciation (book methods)	(31,525,362)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <a href="#">See Attached Schedule</a>	13,468,916		23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 69,370,727	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 81,030,260	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 2,228,956	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,495,000		29
30	Accrued Salaries Payable	1,280,077		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	693,700		32
33	Accrued Interest Payable	517,679		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<a href="#">See Attached Schedule</a>	2,421,012		36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 8,636,424	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	34,808,869		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<a href="#">See Attached Schedule</a>	48,984,026		43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 83,792,895	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 92,429,319	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ (11,399,059)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 81,030,260	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)



**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	<b>\$ (9,984,360)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Prior year cost report reclass of real estate tax refund</b>	<b>(1,751)</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	<b>\$ (9,986,111)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(1,419,637)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants	<b>154,424</b>	<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe) <b>Interest Income</b>	<b>513</b>	<b>15</b>
<b>16</b>	Other (describe) <b>Net Assets released from restriction</b>	<b>(148,248)</b>	<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	<b>\$ (1,412,948)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	<b>\$</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	<b>\$ (11,399,059)</b>	<b>24 *</b>

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

**VII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.  
**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 14,643,886	1
2	Discounts and Allowances for all Levels	(2,424,356)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 12,219,530	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients	580,988	5
6	Therapy	1,524,147	6
7	Oxygen	70,605	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 2,175,740	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	148,986	12
13	Barber and Beauty Care	2,055	13
14	Non-Patient Meals	973	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	948,206	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	17,620	19
20	Radiology and X-Ray	6,725	20
21	Other Medical Services	397,933	21
22	Laundry	55,943	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 1,578,441	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions	84,347	24
25	Interest and Other Investment Income***	568,037	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 652,384	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	See Supplemental Schedule	13,750,013	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 13,750,013	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 30,376,108	30

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	6,184,902	31
32	Health Care	6,940,269	32
33	General Administration	6,867,520	33
	<b>B. Capital Expense</b>		
34	Ownership	6,491,228	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	5,174,951	35
36	Provider Participation Fee	136,875	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 31,795,745	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(1,419,637)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (1,419,637)	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **Friendship Vill. Schaumburg**# **0023218**Report Period Beginning: **04/01/04**Ending: **03/31/05**

## XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,403	1,543	\$ 54,022	\$ 35.01	1
2	Assistant Director of Nursing	4,529	4,982	160,182	32.15	2
3	Registered Nurses	63,370	69,714	2,327,950	33.39	3
4	Licensed Practical Nurses	10,942	12,037	286,305	23.79	4
5	CNAs & Orderlies	185,191	203,730	2,744,884	13.47	5
6	CNA Trainees					6
7	Licensed Therapist	1,158	1,274	36,774	28.86	7
8	Rehab/Therapy Aides	5,279	5,808	75,799	13.05	8
9	Activity Director	7,626	8,389	189,055	22.54	9
10	Activity Assistants	15,625	17,189	194,121	11.29	10
11	Social Service Workers	5,552	6,108	98,003	16.05	11
12	Dietician	2,459	2,705	44,117	16.31	12
13	Food Service Supervisor	2,358	2,594	49,841	19.21	13
14	Head Cook					14
15	Cook Helpers/Assistants	76,805	84,494	1,120,407	13.26	15
16	Dishwashers	20,920	23,014	198,540	8.63	16
17	Maintenance Workers	44,564	49,025	726,607	14.82	17
18	Housekeepers	34,003	37,407	325,628	8.71	18
19	Laundry	18,786	20,667	185,276	8.96	19
20	Administrator	1,891	2,080	92,118	44.29	20
21	Assistant Administrator					21
22	Other Administrative	11,143	12,258	809,761	66.06	22
23	Office Manager					23
24	Clerical	32,567	35,827	955,806	26.68	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	14,595	16,056	188,153	11.72	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	23,938	26,334	511,833	19.44	33
34	TOTAL (lines 1 - 33)	584,701	643,235	\$ 11,375,182 *	\$ 17.68	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

## B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	monthly	4,800	09-03	36
37	Medical Records Consultant	monthly	4,152	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	2,988	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47	<u>Dietary Outside Labor</u>		200,057	01-03	47
48	<u>Chapel Honorarium</u>		18	12-03	48
49	TOTAL (lines 35 - 48)		\$ 212,015		49

## C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	2,740	\$ 130,530	10-03	50
51	Licensed Practical Nurses	660	27,774	10-03	51
52	Certified Nurse Assistants/Aides	15	389	10-03	52
53	TOTAL (lines 50 - 52)	3,415	\$ 158,693		53

SEE ACCOUNTANTS' COMPILATION REPORT

## XIX. SUPPORT SCHEDULES

[illegible]

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

**\*\*See instructions.**

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS** (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

1		2		3		4		5		6		7		8		9		10		11		12		13	
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year																				
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010												
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
2																									
3																									
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20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Friendship Vill. Schaumburg

STATE OF ILLINOIS

# 0023218

Report Period Beginning:

04/01/04

Ending:

Page 23

03/31/05

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. LSN \$24,651
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 109,164 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 136,875  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? Yes (see page 8) For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 973
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 100% in 14  
d. Have vehicle usage logs been maintained? N/A  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
g. Does the facility transport residents to and from day training? No  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: KPMG LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.